

Mail completed application form to:
 Department of Labor & Industries
 Claims Section
 PO Box 44291
 Olympia WA 98504-4201



JOB MODIFICATION ASSISTANCE APPLICATION

One vendor per application form		Date of injury	Claim number
Injured worker's name		Accepted diagnosis	
Vocational counselor/job modification consultant			
Firm's name		Provider number	
Address		Phone number	
City	State	ZIP+4	

Worker's Job title	
Employer name	Phone number

DESCRIPTION OF JOB MODIFICATION

ITEMIZATION OF COSTS: Equipment _____ Tools _____ Other _____ Assembly, installation & delivery _____ Tax _____ Total \$ _____ Employer's portion of costs _____ State Fund or Self-Insured portion of costs _____	REQUIRED DOCUMENTATION <input type="checkbox"/> Job modification narrative report OR <input type="checkbox"/> Job modification consultation report AND <input type="checkbox"/> Bids (if needed) AND <input type="checkbox"/> Ownership agreement	L&I provider number required for payment. If equipment vendor does not have a L&I provider number – Call: Provider Accounts (360) 902-5140 For payment, submit bill on pink "Statement for Retraining and Job Modification Services" form (F245-030-000). Attach copy of approved application
	Vendor name	
	Address	
	City	State ZIP+4
	Provider number	Phone number

Date	Vocational counselor or consultant signature	Employer signature (if contributed to costs)
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For Dept Use Only	<input type="checkbox"/> Approve	<input type="checkbox"/> Authorization code (0380R) entered on AUTH	<input type="checkbox"/> Authorization amount entered on CLOG	<input type="checkbox"/> Disapprove
Date	Signature authority			

Ownership Agreement for Tools and Equipment Purchased as a Job Modification

Worker: _____
Employer: _____

Claim #: _____

Until the modification or return to work is successfully completed, the equipment remains the property of the Department of Labor and Industries.

Upon successful completion of the job modification or return to work, the listed equipment will be owned and maintained by the designated parties. Any equipment owned by the employer must remain available to the worker for use during his or her shift.

Maintenance Responsibility: Safekeeping, proper maintenance and repair of the equipment (beyond the expiration of the manufacturer's warranty, if applicable) are the responsibility of the identified owner.

Return Policy: If the job modification or return to work fails, the equipment must be returned to the Department of Labor and Industries (contact the nearest service location for details). HOWEVER, if the employer participated in the modification, or the equipment is affixed to the work site, the employer may retain the equipment, regardless of the outcome of the modification or return to work.

I understand the agreement as shown above and I am willing to comply with the terms.

Worker Signature

Date

Employer Signature

Date

Equipment/model #	Owner (upon successful completion)

**INSTRUCTIONS FOR COMPLETING THE JOB MODIFICATION ASSISTANCE APPLICATION FORM
(F245-346-000)**

NOTE: SUBMIT A SEPARATE APPLICATION FOR EACH VENDOR.

- 1) **DATE OF INJURY:** Record the date of injury.
- 2) **CLAIM NUMBER:** For the injured worker on whose behalf the application is being submitted.
- 3) **INJURED WORKER'S NAME:** Injured worker's full name.
- 4) **SOCIAL SECURITY NUMBER:** Record injured worker's social security number. It is helpful when the claim number is wrong and the worker's name is common.
- 5) **ACCEPTED DIAGNOSIS:** Record the accepted industrial condition(s).
- 6) **VOCATIONAL COUNSELOR/JOB MODIFICATION CONSULTANT:** Record the name of the individual submitting the application (must be vocational counselor, job modification consultant, or employer that has been trained in completing the applications.) May not be submitted by the worker.
 - a) **FIRM NAME:** Record the firm that the vocational counselor/job modification consultant represents.
 - b) **PROVIDER NO.:** Record the vocational counselor/job modification consultant's provider number.
 - c) **ADDRESS:** Record the vocational counselor/job modification consultant's address and phone number.
- 7) **JOB TITLE:** Record the actual or anticipated job title for which the application is being submitted.
- 8) **EMPLOYER NAME:** Record the employer's name and telephone number for the job title listed.
- 9) **DESCRIPTION OF JOB MODIFICATION:** Briefly list the equipment being requested and the reason for the request.
- 10) **ITEMIZATION OF COSTS:**
 - a) **EQUIPMENT:** Record the cost of equipment being requested.
 - b) **TOOLS:** Record the cost of any tools being requested.
 - c) **OTHER:** Record the cost of non-equipment, non-tool items, such as training time.
 - d) **ASSEMBLY:** Record the cost of assembly, installation and delivery.
 - e) **TOTAL:** Record total cost of modifications requested for this vendor.
 - f) **EMPLOYER'S PORTION:** Record the amount the employer will pay to the vendor.
 - g) **STATE FUND (SF) OR SELF-INSURED (SIE) PORTION:** Record the amount the SF or SIE is asked to pay.
- 11) **REQUIRED DOCUMENTATION**
 - a) **REPORT:** Specify which report type has been included with the application. If the report has been previously submitted, please indicate that it is "on file".
 - b) **BIDS:** Submit two bids for any item over \$1,500.00. If the item is only available from one vendor, please specify that it is a sole source item.
 - c) **OWNERSHIP AGREEMENT:** Must be submitted with the application. A standard ownership agreement for job modifications is available as page 2 of form F245-346-0000.
- 12) **VENDOR:** Enter the vendor's name, address, phone and provider number. Vendors must have a provider number in order to be reimbursed.